SERFF Tracking Number:	*MGCC-126486122*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*44756*
Company Tracking Number:	*CH-26109-APP (01/10)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 Ancil App*		
Project Name/Number:	*Direct Benefit Series/*		

Filing at a Glance

Company: The Chesapeake Life Insurance Company

Product Name: 2010 Ancil App	SERFF Tr Num: MGCC-126486122	State: Arkansas
TOI: H21 Health - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 44756
Sub-TOI: H21.000 Health - Other	Co Tr Num: CH-26109-APP (01/10)	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Kathleen Allen, Jaime Butler, Kim Perkins	Disposition Date: 02/08/2010
	Date Submitted: 02/03/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Direct Benefit Series	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 02/08/2010	Explanation for Other Group Market Type:
	State Status Changed: 02/08/2010
Deemer Date:	Created By: Kathleen Allen
Submitted By: Kathleen Allen	Corresponding Filing Tracking Number:

Filing Description:

Please refer to cover letter under Supporting Documentation tab.

Company and Contact

Filing Contact Information

Kathleen Allen, Senior Compliance Analyst	kathleen.allen@healthmarkets.com
9151 Boulevard 26	817-255-3590 [Phone]
North Richland Hills, TX 76180	817-255-8153 [FAX]

SERFF Tracking Number:	*MGCC-126486122*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*44756*
Company Tracking Number:	*CH-26109-APP (01/10)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 Ancil App*		
Project Name/Number:	*Direct Benefit Series/*		

Filing Company Information

The Chesapeake Life Insurance Company	CoCode: 61832	State of Domicile: Oklahoma
9151 Boulevard 26	Group Code: 264	Company Type: Health
North Richland Hills, TX 76180	Group Name:	State ID Number:
(817) 255-3100 ext. [Phone]	FEIN Number: 52-0676509	

Filing Fees

Fee Required?	Yes
Fee Amount:	$550.00
Retaliatory?	No
Fee Explanation:	11 forms matrix x $50.00 each=$550.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Chesapeake Life Insurance Company	$550.00	02/03/2010	33962724

SERFF Tracking Number:	*MGCC-126486122*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*44756*
Company Tracking Number:	*CH-26109-APP (01/10)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 Ancil App*		
Project Name/Number:	*Direct Benefit Series/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/08/2010	02/08/2010

SERFF Tracking Number:	*MGCC-126486122*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*44756*
Company Tracking Number:	*CH-26109-APP (01/10)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 Ancil App*		
Project Name/Number:	*Direct Benefit Series/*		

Disposition

Disposition Date: 02/08/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MGCC-126486122*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*44756*
Company Tracking Number:	*CH-26109-APP (01/10)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 Ancil App*		
Project Name/Number:	*Direct Benefit Series/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover letter	Approved-Closed	Yes
Supporting Document	Forms approval listing	Approved-Closed	Yes
Supporting Document	MKT/POLICY/SEC MAP	Approved-Closed	Yes
Form	Application-Insurance Coverage Selection Section	Approved-Closed	Yes
Form	Application-Section 1	Approved-Closed	Yes
Form	Application-Section 2	Approved-Closed	Yes
Form	Application-Section 3	Approved-Closed	Yes
Form	Application-Section 4	Approved-Closed	Yes
Form	Application-Section 5	Approved-Closed	Yes
Form	Application-Section 6	Approved-Closed	Yes
Form	Application-Section 7	Approved-Closed	Yes
Form	Application-Section 8	Approved-Closed	Yes
Form	Application-Section 9	Approved-Closed	Yes
Form	Application-Section 10	Approved-Closed	Yes

SERFF Tracking Number:	*MGCC-126486122*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*44756*
Company Tracking Number:	*CH-26109-APP (01/10)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 Ancil App*		
Project Name/Number:	*Direct Benefit Series/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/08/2010	CH-26109-APP (01/10)-ICS	Matrix	Application-Insurance Coverage Selection Section	Initial			CH-26109-APP _0110_-ICS [MATRIX FORMAT].pdf
Approved-Closed 02/08/2010	CH-26109-APP (01/10)-S1	Matrix	Application-Section 1	Initial			CH-26109-APP _0110_-S1 [MATRIX FORMAT].pdf
Approved-Closed 02/08/2010	CH-26109-APP (01/10)-S2	Matrix	Application-Section 2	Initial			CH-26109-APP _0110_-S2 [MATRIX FORMAT].pdf
Approved-Closed 02/08/2010	CH-26109-APP (01/10)-S3	Matrix	Application-Section 3	Initial			CH-26109-APP _0110_-S3 [MATRIX FORMAT].pdf
Approved-Closed 02/08/2010	CH-26109-APP (01/10)-S4	Matrix	Application-Section 4	Initial			CH-26109-APP _0110_-S4 [MATRIX FORMAT].pdf
Approved-Closed 02/08/2010	CH-26109-APP (01/10)-S5	Matrix	Application-Section 5	Initial			CH-26109-APP _0110_-S5 [MATRIX FORMAT].pdf
Approved-Closed 02/08/2010	CH-26109-APP (01/10)-S6	Matrix	Application-Section 6	Initial			CH-26109-APP _0110_-S6 [MATRIX FORMAT].pdf
Approved-Closed 02/08/2010	CH-26109-APP (01/10)-S7	Matrix	Application-Section 7	Initial			CH-26109-APP _0110_-S7 [MATRIX

SERFF Tracking Number:	*MGCC-126486122*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*44756*
Company Tracking Number:	*CH-26109-APP (01/10)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 Ancil App*		
Project Name/Number:	*Direct Benefit Series/*		

						FORMAT].pdf
Approved-Closed 02/08/2010	CH-26109-APP (01/10)-S8	Matrix	Application-Section 8	Initial		CH-26109-APP _0110_-S8 [MATRIX FORMAT].pdf
Approved-Closed 02/08/2010	CH-26109-APP (01/10)-S9	Matrix	Application-Section 9	Initial		CH-26109-APP _0110_-S9 [MATRIX FORMAT].pdf
Approved-Closed 02/08/2010	CH-26109-APP (01/10)-S10	Matrix	Application-Section 10	Initial		CH-26109-APP _0110_-S10 [MATRIX FORMAT].pdf

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

INSURANCE COVERAGE SELECTIONS

[[Vision Plan] *(Vision Insurance Policy Form CH-26023-IP (5/07), or its state variation):* Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[[Dental Plan] *(Dental Insurance Policy Form CH-26099-IP (1/08), or its state variation):* Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]
[☐ Gold] [☐ Silver] [☐ Bronze]

[[Accident Direct Bundle] *{Marketing Name}* Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[Hospital Confinement Direct] *(Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):*
$[250] Daily Benefit Amount
[Accident Direct] *(Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):*
$[10,000] Maximum Accidental Injury Benefit Amount
[Accident Disability Direct] *(Accident-only Disability Income Insurance Policy Form CH-26114-IP (01/10), or its state variation):*
$[500] Monthly Indemnity Benefit [30 Day] Elimination Period [12 Month] Duration]

[[Complete Direct Bundle] *{Marketing Name}* Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[Hospital Confinement Direct] *(Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):*
$[250] Daily Benefit Amount
[Accident Direct] *(Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):*
$[10,000] Maximum Accidental Injury Daily Benefit Amount
[Critical Illness Direct] *(Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation):*
$[5,000] Lifetime Maximum Benefit Amount
[Income Protection Direct] *(Disability Income Insurance Policy Form CH-26115-IP (01/10), or its state variation):*
$[500] Monthly Indemnity Benefit [30 Day] Elimination Period [12 Month] Duration]

[[Hospital Direct Bundle] *{Marketing Name}* Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[Hospital Confinement Direct] *(Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):*
$[250] Daily Benefit Amount
[Accident Direct] *(Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):*
$[10,000] Maximum Accidental Injury Daily Benefit Amount
[Critical Illness Direct] *(Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation):*
$[5,000] Lifetime Maximum Benefit Amount]

[[ProtectFit Plus Plan] *{Marketing Name}* *(Accidental Injury Only Insurance Policy Form CH-26110-IP (06/09), or its state variation):*
[☐ High Option] [☐ Low Option] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[[HospitalFit Plus Plan] *{Marketing Name}* *(Hospital and Surgical Indemnity Policy Form CH-26111-IP (06/09), or its state variation):*
[☐ High Option] [☐ Low Option] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[[PersonalFit Plus Plan] *{Marketing Name}* *(Sickness-only Scheduled Indemnity Policy Form CH-26112-IP (06/09), or its state variation):*
[☐ High Option] [☐ Low Option] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

INSURANCE COVERAGE SELECTIONS

[[CancerWise] *{Marketing Name}* *(Cancer Benefit Policy Form CH-26055-IP (5/07), or its state variation):*

Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

First Diagnosis Cancer Benefit Amount: [☐ $20,000] [☐ $30,000] [☐ $40,000] [☐ $50,000]]

[[Critical Illness Direct] *{Marketing Name}* *(Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation)*:

Lifetime Maximum Benefit Amount: Applicant ☐1

[☐ $5,000] [☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000] [☐ $70,000] [☐ $80,000] [☐ $90,000] [☐ $100,000]

Lifetime Maximum Benefit Amount: Applicant ☐ 2

[☐ $5,000] [☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000] [☐ $70,000] [☐ $80,000] [☐ $90,000] [☐ $100,000]

Lifetime Maximum Benefit Amount: Applicant(s): ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

[☐ $5,000] [☐ $10,000]]

[[Accident Disability Direct] *{Marketing Name}* *(Accident-only Disability Income Insurance Policy Form CH-26114-IP (01/10), or its state variation):*

Monthly Indemnity Benefit: [☐ $500] [☐ $1,000] [☐ $1,500] [☐ $2,000] [☐ $2,500] Applicant ☐1
Elimination Period: [☐ 14 Days] [☐ 30 Days]
Duration: [☐ 6 Months] [☐ 12 Months] [☐ 18 Months] [☐ 24 Months]

Monthly Indemnity Benefit: [☐ $500] [☐ $1,000] [☐ $1,500] [☐ $2,000] [☐ $2,500] Applicant ☐2
Elimination Period: [☐ 14 Days] [☐ 30 Days]
Duration: [☐ 6 Months] [☐ 12 Months] [☐ 18 Months] [☐ 24 Months]]

[[Income Protection Direct] *{Marketing Name}* *(Disability Income Insurance Policy Form CH-26115-IP (01/10), or its state variation):*

Monthly Indemnity Benefit: [☐ $500] [☐ $1,000] [☐ $1,500] [☐ $2,000] [☐ $2,500] Applicant ☐1
Elimination Period: [☐ 14 Days] [☐ 30 Days]
Duration: [☐ 6 Months] [☐ 12 Months] [☐ 18 Months] [☐ 24 Months]

Monthly Indemnity Benefit: [☐ $500] [☐ $1,000] [☐ $1,500] [☐ $2,000] [☐ $2,500] Applicant ☐2
Elimination Period: [☐ 14 Days] [☐ 30 Days]
Duration: [☐ 6 Months] [☐ 12 Months] [☐ 18 Months] [☐ 24 Months]]

[[Hospital Confinement Direct] *{Marketing Name}* *(Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):*

Daily Benefit Amount: [☐ $250] [☐ $500] [☐ $750] [☐ $1,000] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[[Accident Direct] *{Marketing Name}* *(Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):*

Maximum Accidental Injury Benefit Amount: Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

[☐ $5,000] [☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000]]

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

SECTION [1] - APPLICABLE TO ALL PLANS

☐ New Applicant ☐ Re-apply

Primary Applicant Name: _____ Agent Name: _____ Agent ID #: _____
Last First MI

Applicant's Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

Daytime Phone: (____) _____ Home Phone: (____) _____

Cell Phone: (____) _____ Fax Number : (____) _____

Best Time to Call: ☐ AM ☐ PM ☐ Home ☐ Work ☐ Cell

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Common Law

Are all Applicants U.S. Citizens? ☐ Yes ☐ No. If "No," explain: _____

How long in the U.S.? _____ ☐ Work Permit ☐ Visa Type of Visa: _____ Expiration Date: __/__/__

SCHEDULE OF APPLICANTS

Please Print (Full Name)	Sex	Relationship	DOB	Age	Ht.	Wt.	Tobacco or Nicotine substitute use in last 12 months?	Social Security #	ID# *(HO use only)*
(1)		Primary					☐ YES ☐ NO		
(2)		Spouse					☐ YES ☐ NO		
(3)							☐ YES ☐ NO		
(4)							☐ YES ☐ NO		
(5)							☐ YES ☐ NO		
(6)							☐ YES ☐ NO		
(7)							☐ YES ☐ NO		
(8)							☐ YES ☐ NO		

1. Has any Applicant lived or traveled outside of the U.S. or Canada for more than two of the last 12 months? ☐ Yes ☐ No
   If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

2. Are all proposed dependent Applicants (other than Spouse) either: (1) under age 19; (2) full-time students (between ages 19-24); or (3) incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent on the primary Applicant for support and maintenance?
   If "No," indicate Applicant(s): ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐ Yes ☐ No

If applying for [VISION PLAN] and/or [DENTAL PLAN] ONLY, please proceed to [SECTION 10].

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

SECTION [2] - APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT DIRECT BUNDLE]
[♦ HOSPITAL DIRECT BUNDLE]
[♦HOSPITALFIT PLUS]
[♦ INCOME PROTECTION DIRECT]
[♦ ACCIDENT DIRECT]
[♦ COMPLETE DIRECT BUNDLE]
[♦PROTECTFIT PLUS]
[♦ ACCIDENT DISABILITY DIRECT]
[♦ HOSPITAL CONFINEMENT DIRECT]

[3]. Does any Applicant currently or in the future plan to participate in any volunteer police or firefighting activities; plan to participate in mountaineering using ropes and/or any other equipment; parachuting/skydiving; base jumping; heli-snowboarding; heli-skiing; hang gliding; plan to participate in any hazardous sport or activity; or plan to race any type of vehicle in an organized event? ☐ Yes ☐ No

If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

SECTION [3] - APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT DIRECT BUNDLE]	***[♦ COMPLETE DIRECT BUNDLE]***
[♦ HOSPITAL DIRECT BUNDLE]	***[♦PROTECTFIT PLUS]***
[♦HOSPITALFIT PLUS]	***[♦PERSONALFIT PLUS]***
[♦CANCERWISE]	***[♦ CRITICAL ILLNESS DIRECT]***
[♦ ACCIDENT DISABILITY DIRECT]	***[♦ INCOME PROTECTION DIRECT]***
[♦ HOSPITAL CONFINEMENT DIRECT]	***[♦ ACCIDENT DIRECT]***

[4]. Is any Applicant eligible for or covered under Medicare or Medicaid? ☐ Yes ☐ No
If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

[5]. (a) Occupation/duties of Primary Applicant: _____

(Complete if applying for Spouse)
(b) Occupation/duties of Spouse Applicant:: _____

[6]. Has any Applicant been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, or tested positive for Human Immunodeficiency Virus (HIV) or an AIDS-related test? ☐ Yes ☐ No
If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

If applying for [ACCIDENT DIRECT BUNDLE,] [PROTECTFIT PLUS PLAN] ONLY, please proceed to [SECTION 10].

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

SECTION [4] - APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ COMPLETE DIRECT BUNDLE]
[♦HOSPITALFIT PLUS]
[♦CANCERWISE]
[♦ ACCIDENT DISABILITY DIRECT]
[♦ HOSPITAL CONFINEMENT DIRECT]
[♦ HOSPITAL DIRECT BUNDLE]
[♦PERSONALFIT PLUS]
[♦ CRITICAL ILLNESS DIRECT]
[♦ INCOME PROTECTION DIRECT]

[7]. In the last two years, has any Applicant received a recommendation from a Physician to be hospitalized or to have surgery that has not yet occurred? ☐ Yes ☐ No
If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

[8]. Within the past 60 days has any Applicant had or been advised by a Physician to have any testing or any treatment which has not yet occurred, for which results are still pending, and/or that requires follow-up that has not been completed? ☐ Yes ☐ No
If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

If applying for [COMPLETE DIRECT BUNDLE, and/or] [HOSPITAL DIRECT BUNDLE] ONLY, please proceed to [SECTION 10].

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

SECTION [5] - APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT DIRECT] ***[♦ ACCIDENT DISABILITY DIRECT]***

[9]. *Has any Applicant had symptoms that resulted in a diagnosis or treatment (including medication) for **any** of the following: Stroke, Multiple Sclerosis, Huntington's disease, Muscular Dystrophy, Guillain-Barre syndrome, Epilepsy, seizures, paralysis, Parkinson's, Cerebral Palsy, or Alzheimer's, in the last 12 months*?
If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐ Yes ☐ No

If applying for [ACCIDENT DIRECT PLAN] ONLY, please proceed to [SECTION 10].

L O G O
I N S E R T H E R E

APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

SECTION [6] - APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦CANCERWISE] ***[♦ CRITICAL ILLNESS DIRECT]***

[10]. ***In addition to this application***, does any Applicant currently have or plan to apply for any critical illness/specified disease or cancer insurance under this and/or any other Insurance Company, with combined benefits exceeding $60,000, that will not be replaced with the coverage being applied for? ☐ Yes ☐ No
If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

SECTION [7] - APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦HOSPITALFIT PLUS] ***[♦PERSONALFIT PLUS]***
[♦CANCERWISE] ***[♦ CRITICAL ILLNESS DIRECT]***
[♦ INCOME PROTECTION DIRECT] ***[♦ HOSPITAL CONFINEMENT DIRECT]***

[11]. During the past two years, has any Applicant had life, disability, or any health insurance declined, postponed, or rescinded? ☐ Yes ☐ No
If "Yes": ☐ With This Insurance Company ☐ With Another Insurance Company
If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
Reasons for re-application: _____

[12]. Has any Applicant had symptoms, been diagnosed, received medical advice or been treated for any of the following:
(a) 2 or more occurrences of Skin Cancer other than melanoma, within last 12 months? ☐ Yes ☐ No
(b) recurrent breast tumors, polycystic disease, non-malignant growths/tumors, or neoplasms, within the last 3 years? ☐ Yes ☐ No
(c) melanoma, breast cancer, prostate cancer, colon cancer, Hodgkin's Disease, non-Hodgkin's Lymphoma, leukemia, or other malignant growths or tumors *(excluding conditions listed in 12 (a) or 12 (b))*, within the last 10 years? ☐ Yes ☐ No
If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

[13]. Has any Applicant been advised of any abnormal diagnostic test results (pelvic exam/pap smear, mammogram, prostate/PSA exam, colorectal cancer screening), or been advised to have any diagnostic testing which has not yet been completed, within the last two years? ☐ Yes ☐ No
If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

[14]. Has any Applicant had symptoms, been diagnosed, received medical advice or been treated for: emphysema, hemochromatosis, ulcerative colitis or Crohn's, cirrhosis, hepatitis (excluding type A), COPD (chronic obstructive pulmonary disorder), within the last 10 years? ☐ Yes ☐ No
If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

[15.] Family History: Does any Applicant have two or more immediate family members (biological parents or siblings), living or deceased, who have each had one or more of the following prior to age 65:
(a) Any form of cancer other than skin cancer? ☐ Yes ☐ No
If any "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
(b) Heart Disease, Stroke, Diabetes (type I), Kidney Disease, Liver Disease, Alzheimer's or Senile Dementia? ☐ Yes ☐ No
If any "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

If applying for [CANCERWISE] ONLY, please proceed to [SECTION 10].

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

SECTION [8] - APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦HOSPITALFIT PLUS] ***[♦PERSONALFIT PLUS]***
[♦ CRITICAL ILLNESS DIRECT] ***[♦ INCOME PROTECTION DIRECT]***
[♦ HOSPITAL CONFINEMENT DIRECT]

[16]. Is any Applicant currently confined in a hospital or nursing home, or has any Applicant received medical advice or treatment for Alzheimer's Disease or Senile Dementia, or does any Applicant require human assistance of any kind to perform activities of daily living (bathing, dressing, continence, eating, or using the toilet)? ☐ Yes ☐ No

If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

[17]. (a) Is the Applicant or spouse (even if not proposed for insurance): (1) now pregnant or an expectant father; (2) being tested for or receiving treatment for fertility/infertility; or (3) in the process of adoption or surrogacy (with anyone, whether or not this person is applying for coverage)? ☐ Yes ☐ No

(b) Is any proposed dependent Applicant (other than Spouse): (1) now pregnant or an expectant father; (2) being tested for or receiving treatment for fertility/infertility; or (3) in the process of adoption or surrogacy (with anyone, whether or not this person is applying for coverage)? ☐ Yes ☐ No

If "Yes," indicate Applicant(s): ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

[18]. Has any Applicant had symptoms, been diagnosed, received medical advice or been treated for ***any*** of the following:

(a) Cholesterol/Blood Pressure: Uncontrolled hyperlipidemia (an LDL cholesterol reading of 150 or greater or a triglycerides reading of 325 or greater), uncontrolled hypertension (a Systolic reading of 150 or greater or Diastolic reading of 95 or greater), within the last 6 months?	☐ Yes ☐ No	(e) Endocrine System: Diabetes (type I or II), within the last 10 years?	☐ Yes ☐ No
		(f) Connective Tissue Disease or Disorder: Systemic Lupus (SLE) or sarcoidosis, within the last 10 years?	☐ Yes ☐ No
(b) Mental Diseases or Disorders: Bipolar disorder, Schizophrenia, major depressive disorder, manic disorder, alcoholism, alcohol abuse, drug abuse or drug addiction, within the last 3 years?	☐ Yes ☐ No	(g) Respiratory System: Lung disease or Cystic Fibrosis, within the last 10 years?	☐ Yes ☐ No
(c) Heart and Circulatory System: Heart disorder or disease, blood clots, blood vessel blockages, myocardial infarction (heart attack), stroke, mini-stroke (including transient ischemic attack), any form of heart surgery, or aneurysms, within the last 10 years?	☐ Yes ☐ No	(h) Nervous System: Multiple Sclerosis, Huntington's disease, Muscular Dystrophy, Guillain-Barre syndrome, Epilepsy, seizures, paralysis, or traumatic brain injury, within the last 10 years?	☐ Yes ☐ No
(d) Renal System: Abnormal kidney functions (excludes kidney stones), chronic renal failure, or End Stage Renal Disease, within the last 10 years?	☐ Yes ☐ No	(i) Fainting, dizziness, chronic headaches, sudden vision deterioration, loss of depth perception, sudden hearing loss, or loss of balance control, any of which were unexplained and occurred within the last 12 months?	☐ Yes ☐ No

If "Yes" to any of the above, indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

If applying for [HospitalFit Plus,][PersonalFit Plus,][Critical Illness Direct,][Hospital Confinement Direct] ONLY, please proceed to [SECTION 10].

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

SECTION [9] - APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT DISABILITY DIRECT] ***[♦ INCOME PROTECTION DIRECT]***

[19]. Has any Applicant ever been convicted of any felony activity? ☐ Yes ☐ No
If "Yes," indicate Applicant(s): ☐1 ☐2

[20]. (a) Has the Primary Applicant been performing the previously listed occupation/duties (or similar occupations/duties) or been employed with his/her current employer, for more than 12 months? ☐ Yes ☐ No

(Complete if applying for Spouse)
(b) Has the Spouse Applicant been performing the previously listed occupation/duties (or similar occupations/duties) or been employed with his/her current employer, for more than 12 months? ☐ Yes ☐ No

[21]. (a) Does the Primary Applicant work 30 or more hours per week in the occupation/duties previously listed? ☐ Yes ☐ No

(Complete if applying for Spouse)
(b) Does the Spouse Applicant work 30 or more hours per week in the occupation/duties previously listed? ☐ Yes ☐ No

[22]. (a) What is the Primary Applicant's annual gross income from the occupation/duties previously listed? $_____

(Complete if applying for Spouse)
(b) What is the Spouse Applicant's annual gross income from the occupation/duties previously listed? $_____

[23]. In the last five years has any Applicant been hospitalized or had surgery for spine, neck or back, or surgical joint repair or replacement? ☐ Yes ☐ No

[24] Within the last 6 months has any Applicant received treatment (excluding chiropractic treatments or physical therapy, less than once per month) or has any Applicant taken prescription medication for conditions/disorders related to the spine, neck or back, or joints (shoulders, knees, hips or ankles)? ☐ Yes ☐ No

[25]. In addition to this application, does any Applicant currently have or plan to apply for any disability coverage with any Insurance Company that will not be replaced with the coverage being applied for? ☐ Yes ☐ No

[26]. Has any Applicant currently or within the last 5 years filed a claim or received benefits from any disability insurance or salary continuation plan for disability *(other than pregnancy)?* ☐ Yes ☐ No

[27]. Has any Applicant had symptoms, been diagnosed, received medical advice or been treated for sleep apnea, fibromyalgia, Parkinson's, chronic fatigue syndrome, unresolved carpal tunnel syndrome, rheumatoid arthritis, or Epstein Barr, within the last 12 months? ☐ Yes ☐ No

If any "Yes" to questions [23] – [27], indicate Applicant(s): ☐1 ☐2

Please proceed to [SECTION 10].

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

SECTION [10] – APPLICABLE TO ALL PLANS

BILLING INFORMATION

Initial Payment: ☐ACH (Auth Section Required) [☐Credit Card] [☐Direct Pay]	Bill Type: ☐ACH (Auth Section Required) [☐Credit Card] ☐e-Bill
☐ Individual Billing / Mode: (If applicable) ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually	
☐ Single ☐ Primary and Spouse ☐ Primary and Child(ren) ☐ Family	Relationship of Payor to Primary Applicant: ☐ Self ☐ Parent/Guardian ☐ Other If "Other" who, and reason for such:_____
For Office Use Only Premium Amount quoted [(including $[20] one-time application fee)]: $_____ [Check #: _____(if collected at sale)]	Proposed Effective Date of Coverage: _____ Special Request(s):_____

DECLARATIONS AND AGREEMENTS

I agree that: (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) the agent does not have the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage; [*(d) no person to be covered under the [CancerWise] plan (Cancer Benefit Policy Form CH-26055-IP (5/07), or its state variation) or [Critical Illness Direct] plan (Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation) is also covered by any Title XIX program (Medicaid, MediCal or any similar name);] and ([e])* no insurance will take effect unless and until the Application is approved by the Company and the Policy is delivered to the Applicant ***while the conditions affecting the insurability are and have remained as described herein and the first premium has been paid in full.***

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and is subject to criminal and/or civil penalties.

I have received and understand the Notification of Consumer Report and Medical Information Bureau Pre-Notice.

Signed _____/_____/_____ at _____, _____
Date Resident City Resident State

X_____ X_____
Signature of Primary Applicant Signature of Spouse Applicant (If to be covered)

TO BE ANSWERED BY AGENT:
I certify that each question on this application was asked by me of the Applicant(s) named above, and all answers are accurately recorded.

X _____
Signature of Licensed Agent Print Full Name Agent Number

L O G O
I N S E R T H E R E

APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

FOR HOME OFFICE USE ONLY:	
Agency Lead #:_____ ☐ Ref. ☐ PDL	Source of Sale ID: ☐ Paper App ☐ EApp ☐ Sold with other products from same company or carrier ☐ Agent Direct to Individual ☐ Other_____
Family / Grouping Code ID:	Association ID:
Writing Agent ID #:	Alternate Agent of Record ID #:
Application ID #:	Product Type:
Enrollment ID #:	Image ID #:

SERFF Tracking Number:	*MGCC-126486122*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*44756*
Company Tracking Number:	*CH-26109-APP (01/10)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 Ancil App*		
Project Name/Number:	*Direct Benefit Series/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	02/08/2010

Comments:
Please refer to attached.

Attachments:
ARGA 0104.pdf
Cert Compl Rule-Reg19 -AR.pdf
Cert Compliance AR-Readability.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	02/08/2010

Comments:
Please refer to Form Schedule tab.

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	02/08/2010
Bypass Reason:	Not applicable		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	02/08/2010
Bypass Reason:	Not applicable		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Cover letter	Approved-Closed	02/08/2010

Comments:

SERFF Tracking Number:	*MGCC-126486122*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*44756*
Company Tracking Number:	*CH-26109-APP (01/10)*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*2010 Ancil App*		
Project Name/Number:	*Direct Benefit Series/*		

Please refer to attached.

Attachment:

CH-26109-APP _0110_ [Indiv].pdf

		Item Status:	**Status Date:**
Satisfied - Item:	Forms approval listing	Approved-Closed	02/08/2010

Comments:

Please refer to attached.

Attachment:

CHESAPEAKE LIST OF SUPP POLICIES.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	MKT/POLICY/SEC MAP	Approved-Closed	02/08/2010

Comments:

Please refer to attached.

Attachment:

MKTG-POLICY-SEC MAP CH-26109-APP _0110_.pdf

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract..

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice.

The Arkansas Life and Health Insurance Guaranty Association
C/O The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net coverage is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and they hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies or contracts are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws or another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;

- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to suture assessments, or by an insurance exchange.

The Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administra6tion of a policy by a group contract holder;
- Employers' plans, to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders , not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of any unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments r4equired by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits for net cash surrender values – again, no matter how many policies and contracts there were wit hteh same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets if the impaired or insolvent insurer.]

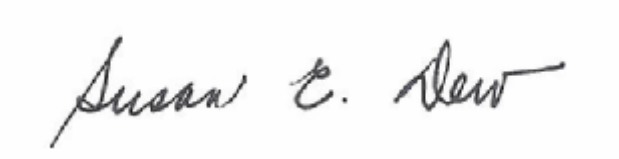
Certificate of Compliance with
Arkansas Rule and Regulation 19

Insurer: The Chesapeake Life Insurance Company

Form Number(s):

CH-26109-APP (01/10) et al…

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



_____
Signature of Company Officer

Susan Dew
_____
Name

Senior Vice President, Associate General Counsel and Chief Compliance Officer
_____
Title

February 3, 2010
_____
Date

Certificate of Compliance for Arkansas

This is to certify the attached form has achieved the Flesch Reading Ease Score given below and complies with the requirements of Arkansas Stat. Ann, 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language simplification Act.

Form Numbers and Form Names:

CH-26109-APP (01/10) et al…Application

Flesch Reading Score:

51.0

Susan Dew, Senior Vice President, Associate General Counsel and Chief Compliance Officer

February 3, 2010

Date

The Chesapeake
Life Insurance Company
Home Office: Oklahoma City, OK

9151 Boulevard 26
North Richland Hills, TX 76180

February 3, 2010

Arkansas Insurance Department
Life and Health Division
1200 W 3rd Street
Little Rock, AR 72201-1904

RE: THE CHESAPEAKE LIFE INSURANCE COMPANY
NAIC#: 264-61832 FEIN#: 52-0676509
SERFF Tracking Number: MGCC-1267486122

Application Form Sections	**DESCRIPTION**
CH-26109-APP (01/10)-ICS	Application-Insurance Coverage Selection Section
CH-26109-APP (01/10)-S1	Application-Section 1
CH-26109-APP (01/10)-S2	Application-Section 2
CH-26109-APP (01/10)-S3	Application-Section 3
CH-26109-APP (01/10)-S4	Application-Section 4
CH-26109-APP (01/10)-S5	Application-Section 5
CH-26109-APP (01/10)-S6	Application-Section 6
CH-26109-APP (01/10)-S7	Application-Section 7
CH-26109-APP (01/10)-S8	Application-Section 8
CH-26109-APP (01/10)-S9	Application-Section 9
CH-26109-APP (01/10)-S10	Application-Section 10

SUPPORTING DOCUMENTATION:	
"FORMS LISTING"	Chesapeake Forms Listing
"MKTG/POLICY/SEC MAP..."	Marketing Name to Policy Form to Question Section Map

Dear Examiner:

The above referenced sections which create one application form are hereby submitted for your review and approval**.** This form is new and not intended to replace any forms previously approved by your Department.

This application form is intended to be used to solicit coverage at this time under the policy forms specified on the attached **"Forms Listings"** page. This document is intended to be supporting documentation only in order to assist the Department in its review.

It is our hope that we may also be granted the flexibility to solicit coverage using this application for future-approved supplemental health insurance policies.

For your ease of reference, the attached **"MKT/POLICY/SEC MAP..."** is an outline of which sections apply to each Policy, with the Policy's form number, type of insurance, and current marketing name. This document is intended to be supporting documentation only in order to assist the Department in its review.

This application form may also be used in an electronic format, and to solicit any products approved by your Department in the future.

The Chesapeake
Life Insurance Company
Home Office: Oklahoma City, OK

The bracketed information is intended to be variable. To the best of our knowledge, information and belief, the form submitted herewith is in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state.

Should you need anything further in order to expedite this request, please do not hesitate to contact me at any of the options referenced below.

Your assistance in this matter is greatly appreciated.

Sincerely,

Kathleen Allen

Senior Compliance Analyst
Corporate Compliance

HealthMarkets®

9151 Boulevard 26 • North Richland Hills • TX 76180
P (817) 255-3590 • **F** (817) 255-8153
Kathleen.Allen@HealthMarkets.com • www.HealthMarkets.com

FORMS LISTING
THE CHESAPEAKE LIFE INSURANCE COMPANY

List of policy forms approved and/or pending approval by AR that CH-26109-APP (01/10); et al will be used to solicit coverage under:

FORM NUMBER	FORM TYPE	APPROVAL DATE	SERFF ID
CH-26023-IP (5/07) AR	Vision Insurance Policy	8/6/07	MGCC-126182588
CH-26055-IP (5/07) AR	Cancer Benefit Policy	5/25/07	MGCC-125182595
CH-26099-IP (1/08)	Dental Insurance Policy	4/22/08	MGCC-125612182
CH-26110-IP (06/09) AR	Accidental Injury Only Insurance Policy	7/29/09	MGCC-126242277
CH-26111-IP (06/09) AR	Hospital and Surgical Indemnity Policy	7/29/09	MGCC-126242370
CH-26112-IP (06/09) AR	Sickness-Only Scheduled Indemnity Policy	7/29/09	MGCC-126242394
CH-26113-IP (01/10) AR	Specified Disease/Condition & Major Organ Transplant Policy	1/15/10	MGCC-126418917
CH-26114-IP (01/10) AR	Accident-Only Disability Income Insurance Policy	12/16/09	MGCC-126419061
CH-26115-IP (01/10) AR	Disability Income Insurance Policy	12/16/09	MGCC-126419166
CH-26116-IP (01/10) AR	Hospital Confinement Indemnity Policy	12/16/09	MGCC-126419273
CH-26118-IP (01/10) AR	Accidental Injury Only Insurance Policy	12/16/09	MGCC-126419306

MARKETING NAME to POLICY FORM to QUESTION SECTION MAPPING

MARKETING NAME	POLICY FORM NAME	POLICY FORM SERIES	APPLICABLE SECTION(S)
"[Vision Plan]"	Vision Insurance Policy	CH-26023-IP (5/07)	☑ 1 ☑ 10
"[CancerWise]"	Cancer Benefit Policy	CH-26055-IP (5/07)	☑ 1 ☑ 3 ☑ 4 ☑ 6 ☑ 7 ☑ 10
"[Dental Plan]"	Dental Insurance Policy	CH-26099-IP (1/08)	☑ 1 ☑ 10
"[ProtectFit Plus Plan]"	Accidental Injury Only Insurance Policy	CH-26110-IP (06/09)	☑ 1 ☑ 2 ☑ 3 ☑ 10
"[HospitalFit Plus Plan]"	Hospital and Surgical Indemnity Policy	CH-26111-IP (06/09)	☑ 1 ☑ 2 ☑ 3 ☑ 4 ☑ 7 ☑ 8 ☑ 10
"[PersonalFit Plus Plan]"	Sickness-only Scheduled Indemnity Policy	CH-26112-IP (06/09)	☑ 1 ☑ 3 ☑ 7 ☑ 8 ☑ 10
"[Critical Illness Direct]"	Specified Disease/Condition & Major Organ Transplant Policy	CH-26113-IP (01/10)	☑ 1 ☑ 3 ☑ 4 ☑ 6 ☑ 7 ☑ 8 ☑ 10
"[Accident Disability Direct]"	Accident-only Disability Income Insurance Policy	CH-26114-IP (01/10)	☑ 1 ☑ 2 ☑ 3 ☑ 4 ☑ 5 ☑ 9 ☑ 10
"[Income Protection Direct]"	Disability Income Insurance Policy	CH-26115-IP (01/10)	☑ 1 ☑ 2 ☑ 3 ☑ 4 ☑ 7 ☑ 8 ☑ 9 ☑ 10
"[Hospital Confinement Direct]"	Hospital Confinement Indemnity Policy	CH-26116-IP (01/10)	☑ 1 ☑ 2 ☑ 3 ☑ 4 ☑ 7 ☑ 8 ☑ 10
"[Accident Direct]"	Accidental Injury Only Insurance Policy	CH-26118-IP (01/10)	☑ 1 ☑ 2 ☑ 3 ☑ 5 ☑ 10
"[Accident Direct Bundle]" INCLUDES:			☑ 1 ☑ 2 ☑ 3 ☑ 10
• [" Accident Disability Direct"	Accident-only Disability Income Insurance Policy	CH-26114-IP (01/10)	
• " Hospital Confinement Direct"	Hospital Confinement Indemnity Policy	CH-26116-IP (01/10)	
• " Accident Direct"	Accidental Injury Only Insurance Policy	CH-26118-IP (01/10)]	
"[Hospital Direct Bundle]" INCLUDES:			☑ 1 ☑ 2 ☑ 3 ☑ 4 ☑ 10
• [Critical Illness Direct	Specified Disease/Condition & Major Organ Transplant Policy	CH-26113-IP (01/10)	
• Hospital Confinement Direct	Hospital Confinement Indemnity Policy	CH-26116-IP (01/10)	
• Accident Direct	Accidental Injury Only Insurance Policy	CH-26118-IP (01/10)]	
"[Complete Direct Bundle]" INCLUDES:			☑ 1 ☑ 2 ☑ 3 ☑ 4 ☑ 10
• [Critical Illness Direct	Specified Disease/Condition & Major Organ Transplant Policy	CH-26113-IP (01/10)	
• Income Protection Direct	Disability Income Insurance Policy	CH-26115-IP (01/10)	
• Hospital Confinement Direct	Hospital Confinement Indemnity Policy	CH-26116-IP (01/10)	
• Accident Direct	Accidental Injury Only Insurance Policy	CH-26118-IP (01/10)]	